This form in its entirety must be completed and signed prior to your appointment.

PATIENT MEDICAL HISTORY **SPINE & JOINT SOLUTIONS PLLC**

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Reason for visit: _____

Allergies

Have you ever had a bad reaction to any type of steroid (oral, topical, injectable, etc.)? ☐yes ☐no

Type of Steroid: _____ Reaction: _____

Are you allergic to contrast, IV dye or iodine? ☐yes ☐no Reaction: _____

Are you allergic to any medications? ☐yes ☐no

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to any foods or other items? ☐yes ☐no

Product: _____ Reaction: _____

Past Medical History

List current medical conditions. (i.e. hypertension, diabetes)

_____

_____

Surgeries

List surgeries and approximate dates.

_____

_____

Family History (Please specify family member and disease.)

_____

_____

Social History

Occupation: _____ Company Name: _____ How long at company? _____

Drink alcohol: ____ Currently ____ Past ____ Never How much and how often? _____

Use tobacco products: ____ Currently ____ Past ____ Never How much and how often? _____

Substance abuse: ____ Currently ____ Past ____ Never How much and how often? _____

Medications with Dosages Please include prescription and over-the-counter medications. (Use other pages if needed.)

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Medication: _____ Dosage: _____ Reason: _____

Pharmacy

Preferred pharmacy name: _____

Preferred pharmacy location: _____

Patient Acknowledgment

To the best of my knowledge, the information provided above is accurate and complete.

_____ _____

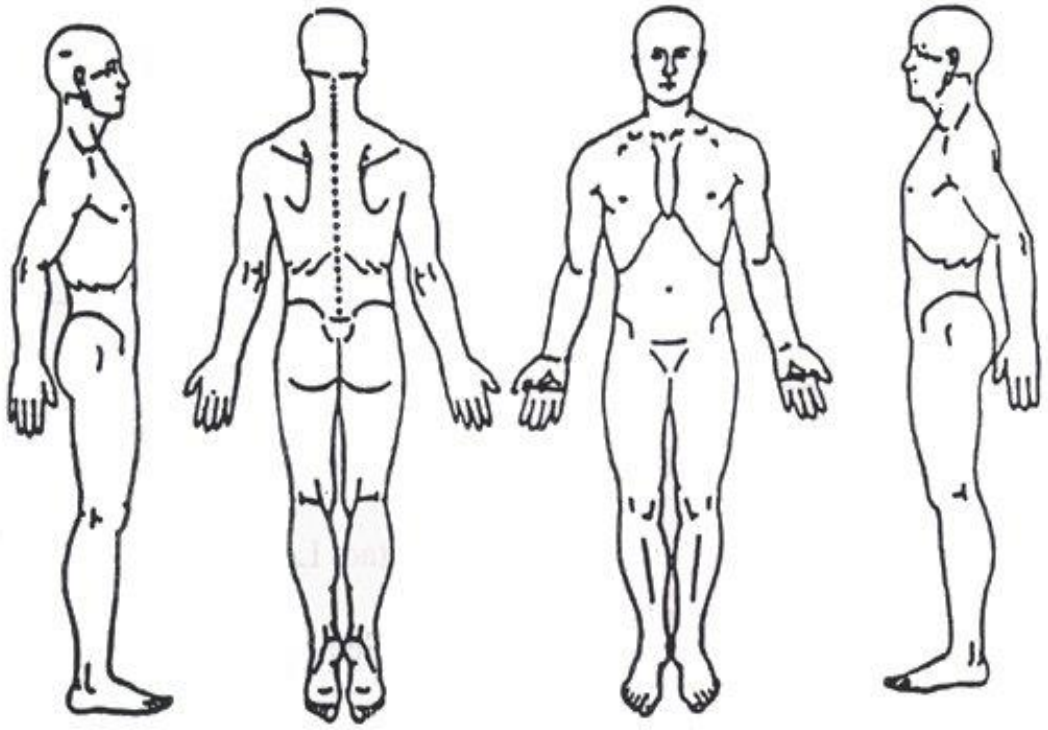
Signature of Patient or Authorized Person Date

PAIN DIAGRAM **SPINE & JOINT SOLUTIONS PLLC**

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Using the symbols given below, mark the area on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles/Tingling	Burning	Stabbing	Other
o o o o	- - - - - - - -	/ / / / / / / / / / / / / /	+ + + +	X X X X	? ? ?



PAIN SCALE

No Pain		Low		Moderate			Intense			Unbearable
0	1	2	3	4	5	6	7	8	9	10

This form in its entirety must be completed, fully initialed and signed prior to your appointment. ***Print clearly & press firmly in black ink***

FINANCIAL POLICY **Spine & Joint Solutions PLLC**

Patient Name _____
Last First MI

Date of Birth _____ SSN _____ Today's Date _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

ASSIGNMENT: I request that payment of authorized insurance and Medicare benefits be made payable to Spine & Joint Solutions PLLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Spine & Joint Solutions PLLC to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ ***(Initial) I have read and agree to the above statement.***

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____ ***(Initial) I have read and agree to the above statement.***

AUTOMOBILE ACCIDENT: I understand that Spine & Joint Solutions does not accept deferred payment through auto liens. If my injury is the result of an auto accident and MedPay is exhausted, the private medical insurance will be billed. I understand that if the claim is denied, I will be responsible for payment in full. I understand that if the claim is originally paid by insurance but then insurance demands a return of payment or does a take-back of funds (even if this occurs years after treatment), I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney will be provided to this office.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

_____ ***(Initial) I have read and agree to the above statement.***

NO SHOW/LATE CANCEL POLICY: I understand and agree to pay a $50.00 charge for appointments that I do not honor or do not cancel earlier than 48 business hours prior to the scheduled appointment.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Spine & Joint Solutions PLLC and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____ ***(Initial) I have read and agree to the above statement.***

PAYMENT: I agree that if my insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ ***(Initial) I have read and agree to the above statement.***

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages. Your attending physician may have an ownership interest in one or more Ambulatory Surgery Center. Please contact the office manager if you have any questions. By signing below, I indicate that I understand that Spine & Joint Solutions is not contracted with Medicaid, and I attest that I am not a recipient of Medicaid.

PRINT NAME _____

SIGNATURE _____ DATE _____

This form in its entirety must be completed and signed prior to your appointment.

PATIENT REGISTRATION FORM

Spine & Joint Solutions PLLC

(Print clearly & press firmly in black ink)

Today's Date_____

Patient Name_____
Last First MI Nickname

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____ May we email detailed information? (circle) YES / NO

Primary Phone ( )_____ May we leave a detailed message? (circle) YES / NO

Secondary Phone ( )_____ May we leave a detailed message? (circle) YES / NO

Patient's Employer_____

Primary reason for today's visit_____

Primary Care Physician_____ Referring Physician_____
Last First Last First

Is this work-related? (circle) YES NO If YES, please also complete our Auto/WC Form. We must have a referral from your WC case manager prior to scheduling an appointment.

Is this related to an auto accident or personal injury case? (circle) YES NO If YES, please also complete our Auto/WC Form.

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) Working-Aged ESRD Auto/Med/No Fault Liability Workers Comp Federal Black Lung Veterans Affairs Disability Other Liability

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name_____ Phone ( )_____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone ( )_____ Secondary Phone ( )_____

Custodial Parent's SSN_____ Date of Birth_____

Check Boxes:

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Declined/Undetermined

Race: ☐ 01 Black, African American ☐ 03 White ☐ 09 Native Hawaiian, Other Pacific Islander

☐ 02 Asian ☐ 08 American Indian, Alaska Native ☐ 99 Declined/Undetermined

Preferred Language: ☐ EN-English ☐ FR French ☐ VI-Vietnamese ☐ Other_____

☐ ES-Spanish ☐ ZH-Chinese ☐ KO-Korean

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone ( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone ( )_____ Secondary Phone ( )_____ Relationship_____

_____ _____

Patient Signature (or Parent/Guardian/Other Authorized Person if patient is a minor) Today's Date